Medicare
Intermediary Manual
Part 2 - Audits, Reimbursement, Program Administration

Department of Health & Human Services (DHHS)
The Centers for Medicare & Medicaid Services (CMS)

Transmittal 420 **Date: AUGUST 28, 2002**

CHANGE REQUEST 2118

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2958 (Cont.) - 2959 (Cont.)	2-906.7b - 2-906.23 (17 pp.)	2-906.7b - 2-906.13 (7 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: August 28, 2002*
IMPLEMENTATION DATE: August 28, 2002

Section 2959, Provider Services, changes have been made to publish the FY 02 Budget Performance Requirements already in effect. Pages were added to include: written, e -mail, and telephone inquiry requirements; quality call monitoring process; telephone system troubleshooting, line change and disaster recovery procedures; and a glossary.

These instructions manualize Budget Performance Requirements already in effect.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

complaint should be screened for billing errors or abuse before being sent to the Benefit Integrity Unit. After screening has been performed, if abuse is suspected, the complaint would be handled by the Medical Review Unit. If fraud is suspected, the complaint should be forwarded to the Benefit Integrity Unit and the caller should be told the Benefit Integrity Unit will contact him/her about the complaint. Ask the caller to provide the Benefit Integrity Unit with any documentation he/she may have that substantiates the allegation. Give assurance that the matter will be investigated

10. Equipment Requirements.--To ensure that inquiries receive accurate and timely handling, provide the following equipment:

o On-line access to a computer terminal for each telephone representative responsible for claims-related inquiries to retrieve information on specific claims. Locate the computer terminal so that representatives can research data without leaving their seats;

o An outgoing line for call-backs; and

o A supervisor's console for monitoring telephone representatives' accuracy, responsiveness, clarity, and tone.

11. Telephone Directory Listings.--Effective with the publication of these instructions, intermediaries will not be responsible for the publication of their beneficiary inbound 800 service in any telephone directory. CMS will publish beneficiary inbound 800 numbers in the appropriate directories. No other listings are to be published by the intermediary.

12. Telephone Inbound Service Costs.--Effective with the transition to FTS-2001 service, CMS will pay for the rental of T-1/PRI lines and all connect time charges. These costs will be paid centrally by CMS and only for these telephone service costs. All other costs involved in providing telephone service to Medicare beneficiaries will be born by the contractor. Since these costs are not specifically identified in any cost reports, contractors must maintain records of all costs associated with providing telephone service to beneficiaries (e.g., costs for headsets) and provide this information upon request by RO or CO.

C. Walk-In Inquiries.--

1. General.--Contractors should not actively publicize the walk-in function. However, give individuals making personal visits to you the same high level of service you would give through phone contact. The interviewer must have the same records available as a telephone service representative to answer any questions regarding general program policy or specific claims-related issues.

If a beneficiary inquires about a denied or reduced claim, give him/her the same careful attention given during a "hearing," i.e., the opportunity to understand the decision made and an explanation of any additional information which may be submitted when a review is sought.

Make the same careful recording of the facts as for a telephone response, if it appears further contact or a review will be required.

2. Guidelines for High Quality Walk-In Service.--

o After contact with a receptionist, the inquirer may meet with a service representative;

- o Waiting room accommodations must provide seating;
- o Inquiries must be completed during the initial interview to the extent possible; and
- o Current Medicare publications must be available to the beneficiary.

D. Surveys.--CMS requires annual surveys of customer service operations to be completed by each contractor within the time frames and areas indicated on the specific notice. Examples include annual call center technology surveys, staffing profiles, training needs, etc.

2959. PROVIDER SERVICES

Every member of your customer service team should be committed to providing the highest level of service to our partner, the Medicare provider. This commitment should be reflected in the manner in which you handle each provider inquiry. The following guidelines are designed to help you ensure that this high level of service is provided.

A. Written Inquiries.--

1. Guidelines for Handling Written Inquiries.--Stamp all written inquiries with the date of receipt in the corporate mailroom and control them until you send final answers. In addition:

- o Answer inquiries timely;
- o Do not send handwritten responses;
- o Include a contact's name and telephone number in the response;
- o Consider written appeal requests as valid if all requirements for filing are met. These requests need not be submitted on prescribed forms to be considered valid. If appeal requests are valid, they are not to be considered written inquiries for workload reporting. They should be forwarded to your appeals unit for handling.
- o Include the CMS alpha representation on all responses.
- o Keep responses in a format from which reproduction is possible.

2. Guidelines for High Quality Written Responses to Inquiries.--Contractors must have a correspondence quality control program (containing written policies and procedures) that is designed to improve the quality of written responses. In addition, contractors must perform a continuous quality review of outgoing letters, computer notices, and responses to requests for appeals of initial determinations. These responses should be reviewed based on the following elements:

a. Accuracy.--Content is correct with regard to Medicare policy and your data. Overall, the information broadened the inquirer's understanding of the issues that prompted the inquiry.

b. Responsiveness.--The response addresses the inquirer's major concerns and states an appropriate action to be taken.

c. Clarity.--Letters have good grammatical construction, sentences are of varying length (as a general rule, keep the average length of sentences to no more than 12-15 words), and paragraphs generally contain no more than five sentences. All written inquiries are to be processed using a font size of 12 and a font style of Universal or Times New Roman or another similar style for ease of reading by the provider.

d. Timeliness.--Substantive action is taken and an interim or final response is sent within 45 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 45 calendar days (e.g., inquiry must be referred to a specialized unit for response), send an interim response acknowledging receipt of the inquiry and the reason for any delay.

If you are responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same timeframe for response (i.e., the 45 -day period starts on the same day for both responses).

Ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is most efficient for your conditions. If you respond separately, each response must refer to the fact that the other area of inquiry will be responded to separately.

Every contractor will have the flexibility to respond to provider written inquiries by phone within 45 calendar days. A report of contact should be developed for tracking purposes. The report of contact should include the following information: Provider's name and address, telephone number, provider number, date of contact, internal inquiry control number, subject, summary of discussion, status, action required (if any) and the name of the customer service representative who handled the inquiry. Upon request, send the provider a copy of the report of contact that results from the telephone response. The report of contact should be retained in the same manner and time frame as the current process for written responses. Use your discretion when identifying which written inquiries (i.e., provider correspondence that represent simple questions) can be responded to by phone. Use the correspondence, which includes the requestor's telephone number or use a requestor's telephone number from internal records if more appropriate for telephone responses. If you cannot reach the requestor by phone, do not leave a message for the provider to return the call. A written response should be developed within 45 calendar days from the incoming inquiry if the matter cannot be resolved by phone.

e. Tone.--Tone is the touch that brings communication to a personal level and removes the appearance that a machine-produced response was used. Appraise all responses, including computer-generated letters and form letters, for tone to make them user-friendly and comprehensible by the reader.

f. E-mail Inquiries.--Any e-mail inquiry received can be responded to by e-mail. Since e-mail represents official correspondence with the public, it is paramount that contractors use sound e-mail practices and proper etiquette when communicating electronically. Responses that are personal in nature (contain financial information, HIC#, etc.) cannot be answered by e-mail. Ensure that all e-mail responses utilize the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension).

B. Telephone Inquiries.--The guidelines established below apply to all calls to telephone numbers established as provider inquiry numbers. The standards do not apply to those inquiries handled by other units within the contractor (i.e., appeals, fraud, MSP). To ensure all inquiries are handled as expeditiously as possible, inbound provider inquiry numbers (and the lines) must be separate from beneficiary inquiry numbers. Beneficiaries should not use numbers established for inquiries from providers.

1. Availability of Telephone Service.--Make live telephone service available to callers continuously during normal business hours--**including break and lunch periods.** Call center staffing should be based on the pattern of incoming calls per hour and day of the week ensuring that adequate coverage of incoming calls throughout the workday is maintained in accordance with call center standards. Telephone service must not be interrupted in order to conduct CSR training.

On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work, e.g., provide CSR training.

Although the provider should have the ability to speak with a CSR during operating hours, automated "self-help" tools, such as interactive voice response (IVR) units, may also be used to assist with inquiries. Contractors are encouraged to increase the use of existing IVRs based upon lessons learned and "best practices" throughout CMS and its partners. The IVRs should be updated to address areas of provider confusion as determined through the contractor's inquiry analysis staff and CMS best practices.

Part A intermediaries utilizing IVR technology to assist providers in obtaining answers to various Medicare questions, should offer the following information:

- Contractor hours of operations for live service, provided after hours or during peak times when a caller is waiting on hold;
- General Medicare program information;
- Specific information regarding claims in process and claims completed;
- A statement if additional evidence needed to have a claim processed; and
- General information about appeal rights and actions required of a provider to exercise these rights.

It is recommended the IVR be available to providers from 6 a.m. to 10 p.m. in their local prevailing time, Monday through Friday, and from 6 a.m. to 6 p.m. on weekends and holidays.

Allowances for claims processing system and mainframe availability, as well as for normal IVR and system maintenance shall be made. Contractors should identify what services can be provided to providers during times when the processing system is not available. Contractors should also print and distribute a readily understood IVR operating guide to Medicare providers upon request.

Intermediaries utilizing IVR technology should report the IVR handle rate. This is the number of calls delivered to the IVR where providers received the information they required from the automated system.

2. Toll-Free Telephone Service.--CMS provides toll-free service for providers to all Part A intermediaries. This is accomplished through a government-wide telephone contract negotiated by General Services Administration. This service is known as FTS 2001. The costs associated with the installation and monthly fees for this toll-free service will be paid centrally by CMS. However, Medicare contractors will still be responsible for all other internal wiring and equipment (ACD, IVR, PBX, etc.) and any local telephone services and line charges.

Any toll-free Medicare provider customer service number provided and paid for by CMS must be printed on all provider notices and the contractor's website immediately upon activation. Display this toll-free number prominently so the reader will know whom to contact regarding the notice.

3. Inquiry Staff Qualifications.--Train CSRs to respond to provider questions, whether of a substantive nature, a procedural nature, or both. CSRs who answer telephone calls must be qualified to answer general questions about initial claims determinations, operation of the Medicare program, and appeal rights and procedures. To ensure that these services are provided, CSRs should have the following qualifications:

- Good telephone communications skills;
- Sensitivity for special concerns of the Medicare providers;
- Flexibility to handle different situations that may arise; and
- Experience in Medicare claims processing and review procedures.

Prior experience in positions where the above skills are used, e.g., claims representative or telephone operator, is desired, but not required.

Contractors are required to provide a training program which includes technical instructions on Medicare eligibility, coverage, benefits, claims processing, Medicare systems and administration, use of the Medicare Intermediary Manual , telephone techniques, and the use of a computer terminal.

A proficiency test should be developed for new CSRs and as needed for existing personnel.

4. Guidelines for High Quality Telephone Service.--Handle all provider telephone inquiries in accordance with the guidelines shown below. All tasks related to this activity are mandatory and shall be reported to CMS on a monthly basis. Standard definitions and detailed calculations for each of the required telephone customer service data elements are included as part of the Glossary.

Report total calls offered to the provider call center for the month, defined as the number of calls that reach the call center's telephone system, which can be split up according to trunk lines in instances where a call center is taking calls for Part A, B and other non-CMS calls.

Program all systems related to inbound provider calls to the center to acknowledge each call within 20 seconds (four rings) before a CSR, IVR or automated call distributor (ACD) prompt is reached. This measure may not be required to be reported, but must be substantiated when requested.

For callers choosing to talk with a CSR, answer no less than 85% of calls within the first 60 seconds. This rate should be reported to CMS monthly.

Provide a recorded message, advising callers in queue to speak with a CSR of any temporary delay before a CSR is available. During peak volume periods, indicate in the message a preferred time to call.

NOTE: Program the IVR to provide callers with an after-hours message indicating normal business hours. It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVRs. If call centers have IVRs that allow the recording of messages, this service should be discontinued.

Report call abandonment rate, which is the percentage of provider calls that abandon their call from the ACD queue. This should be reported as two separate measures:

1. Calls abandoned up to and including 60 seconds;
2. Calls abandoned after 60 seconds.

Report the monthly average speed of answer. This is the amount of time that all calls waited before being connected to a CSR. It includes ringing, delay recorder(s) and music.

The CSRs must identify themselves when answering a call, however the use of *both* first and last names in the greeting will be optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR should provide both first and last name. Where the personal safety of the CSR is an issue, call center management should permit the CSR to use an alias. This alias must be known for remote monitoring purposes. The CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

Report monthly average talk time (which includes any time the caller is placed on hold by the CSR).

Handle no less than 80 percent of calls to completion during the initial call - minimizing transfers, referrals and callbacks. This rate should be reported to CMS monthly.

Report call center handling productivity, calculated by the total calls handled divided by the total CSR FTEs in the center.

Report occupancy rate, the percent of time that CSRs spend in active call handling (i.e., on incoming calls, after call work or outbound calls).

Report monthly average after call work time (wrap-time), which includes all the time that the CSR needs to complete all administrative work associated with call activity after the customer disconnects.

Report monthly the status of those calls not resolved at first contact. Those calls should be reported as follows:

1. Callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.

2. Callbacks closed within 5 workdays. This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month.

As needed, develop a corrective action plan to resolve deficient performance in the call center, and maintain results on file for regional office (RO) review.

Develop a proficiency test to be used for new CSRs and as needed for existing personnel. This test should include questions regarding basic aspects of the Medicare program such as benefits and claims processing; review procedures; questions to indicate familiarity with the system and ability to locate and interpret output; how to read information in the computer system and interpret beneficiary file material; new legislation or changes to policy and procedures; and include problems to solve which indicate ability to handle different situations that may arise such as seeking additional information, referring to specialized staff or involving Benefit Integrity Unit.

5. Quality Call Monitoring Process.--Contractors should measure and report the quality of service continuously by employing the quality call monitoring (QCM) process.

Monitor an average of nine calls per CSR per quarter for quality. The CSRs who answer both beneficiary and provider calls need only to be monitored for an average of nine calls per quarter. Focus monitoring efforts on new or other at-risk CSRs who would have the greatest potential to benefit from any feedback while reducing the monitoring frequency on experienced CSRs who have demonstrated a less significant need to be monitored. Individual CSR data shall be analyzed regularly, areas needing improvement identified, and corrective action plans should be implemented and documented.

The sampling routine must ensure that CSRs are monitored at the beginning, middle and end of the month (ensuring that assessments are distributed throughout the week) and during morning and afternoon hours).

Participate in national and regional calibration sessions organized by CMS. Conduct regular monthly calibration sessions.

Monitor the calls in any combination of the following ways: live remote, live side-by-side (shadow), or taped. Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. Complete the scorecard in its entirety and give feedback to the CSR in a timely fashion, coaching and assisting the CSR to improve in areas detected during monitoring.

Copies of the scorecard and chart may be obtained at the telephone customer service Web site at *https://www.hcfa.gov/medicare/callcenter*. Use only the official version of the scorecard posted at the website. Train every CSR and auditor on the scorecard and chart and ensure that each person has a copy of the chart available for reference.

Where possible, rotate auditors regularly among the CSRs. Analyze individual CSR data regularly, identify areas needing improvement, implement and document corrective action plans. Analyze QCM data routinely to determine where training is needed, whether at the individual, team, or call center level.

6. Calls Regarding Claims.--When a telephone representative receives an inquiry from a provider about a claim, first, verify the provider's name, identification number, and note the name and title of the caller. Any information regarding the claim, including why the claim was reduced or denied, may then be discussed with the caller.

7. Calls Regarding Fraud and Abuse.--If a caller indicates an item or service was not received, or that a beneficiary or another provider is involved in some potential fraudulent activity, the complaint should be screened for billing errors or abuse before being sent to the Benefit Integrity Unit. After screening has been performed, if abuse is suspected, the Medical Review Unit would handle the complaint. If fraud is suspected, the complaint should be forwarded to the Benefit Integrity Unit and the caller should be told the Benefit Integrity Unit will contact him/her about the complaint. Ask the caller to provide the Benefit Integrity Unit with any documentation he/she may have that substantiates the allegation. Give assurance that the matter will be investigated.

8. Equipment Requirements.--To ensure that inquiries receive accurate and timely handling, provide the following equipment:

- o On-line access to a computer terminal for each telephone representative responsible for claims-related inquiries to retrieve information on specific claims. Locate the computer terminal so that representatives can research data without leaving their seats;
- o An outgoing line for call-backs; and
- o A supervisor's console for monitoring telephone representatives' accuracy, responsiveness, clarity, and tone.

9. Publicizing Provider Toll Free Lines.--Effective with the publication of these instructions, intermediaries will not be responsible for the publication of their provider inbound 800 service. The CMS will publish provider inbound 800 numbers in the appropriate directories. No other listings are to be published by the intermediary.

However, publicizing the toll-free service to the providers you serve is mandatory. An announcement about the availability of the service should be prominently displayed and maintained on your Medicare Web site. Toll-free numbers should also be displayed on all provider education materials. Finally, you should publicize the toll-free numbers at all scheduled provider conferences, meetings and workshops.

10. Telephone Inbound Service Costs.--The CMS will pay for all costs associated with provisioning FTS 2001 toll free services. All other costs involved in providing telephone service to Medicare provider will be the responsibility of the contractor. Since these costs are not specifically identified in any cost reports, contractors must maintain records of all costs associated with providing telephone service to providers (e.g., costs for headsets) and provide this information upon request by RO or CO.

11. Telephone Service Costs.--The costs involved in providing telephone service to Medicare providers vary considerably from location to location. These costs are not specifically identified in any cost reports. Therefore, maintain records of all costs associated with providing telephone service to providers (e.g., costs per line, costs per call). When requested by RO or CO, provide this information.

C. Processes for Line Changes, Troubleshooting and Disaster Recovery.--

1. Ordering more lines, changing configurations, or disconnecting lines.--The initial installation of provider toll free lines at contractor sites has been completed. The ongoing management of the entire provider toll free system requires a process for making changes, which may be either contractor initiated or CMS-initiated.

The CMS-initiated changes (i.e., adding lines, removing lines, reconfiguring trunk groups) will be based upon an analysis by CO of the data that contractors are now required to report as well as anticipated new reporting requirements as follows. Contractors are to report information on their telephone systems and CSRs performance to CMS.

Any contractor-initiated changes should include an additional analysis of the existing telephone environment and traffic patterns specific to the service being requested. In requesting changes to the phone environment, the contractor should follow the process outlined below.

You will provide an analysis of their current telephone environment including a detailed traffic report that shows the need for changes to their phone system (i.e., additional lines, trunk group reconfiguration). This information should be gathered at the contractor site through the contractor's switch reporting as well as through Interact.

The CMS will review your request and recommend approval, revisions or disapproval. Based on technical merit and availability of funds, CO will review the recommendation and make a determination.

In cases where the request is approved, CO will forward approved requests to the designated agency representative (DAR) for order issuance. In all cases, CO will notify the RO of the outcome.

2. Troubleshooting.--To ensure that provider toll free service is available and clear, CMS established the Provider Incident Reporting & Response System (PIRRS). The PIRRS establishes a standard, incident response and resolution system for Medicare contractors who are troubleshooting problems and processing required changes for the toll free provider lines.

The CMS has assembled a multi-functional team, consisting of both WorldCom telecommunications support and CMS technical support contractor (TSC) personnel; to quickly and effectively resolve reported problems. To report and monitor a problem, follow these steps:

Troubleshooting Steps

Step 1 - Identify the cause and whether it is caused by internal customer premise equipment or toll-free network service:

Internal Problem	Toll-Free Network Service Problem
Your local telecommunications personnel should resolve, but report per steps below.	Report the problem to WorldCom by calling 1-888-387-7821.

Step 2 – Involve CMS's TSC, if needed to answer technical questions or to facilitate discussions with WorldCom.

Step 3 – File an incident report with the TSC for major interruptions of service. The TSC will notify CMS staff. Major interruption of service is defined as any incident with a trouble ticket opened for more than 24 hours or a total loss of service.

Step 4 - Utilize Interact Service Inquiry™ to review documentation, track trouble tickets status, or close a trouble ticket online.

Step 5 - File a monthly report with CMS about interruption of service - including both those of WorldCom and in-house origins and send a copy to your RO.

3. Disaster Recovery.--When a call center is faced with a situation that results in a major disruption of service, it is imperative that the call center take the necessary action to ensure that callers are made aware of the situation.

This service is intended to supplement your existing disaster recovery or contingency plans. Whenever possible, the call center is responsible for activating its own emergency messages or re-routing calls. However, when this is not possible and providers are unable to reach the call center switch, the call center must contact the Beneficiary Network Services Center (BNS) and request that they initiate a pre-scripted disaster recovery message based in the FTS 2001 network. Once the problem is resolved, the call center must also contact the BNS to de-activate the FTS 2001 network disaster messages.

For provider call centers, note that the BNS should only be contacted for the disaster situations and will manage only these types of requests. The single point of contact was designed to streamline the process for shared call centers and avoid making two calls in an emergency situation. The BNS will contact and update the provider TSC when a provider call center disaster situation occurs. For all other FTS 2001 support requests, provider call centers should follow their normal procedures.

D. Provider Inquiries Glossary.--

1. All Trunks Busy.--An ATB situation occurs when every trunk into the call center is unable to accept incoming calls because they are either occupied by other callers or are non-operational. This results in incoming callers receiving a busy signal when trying to connect to the call center, until one or more trunks are made available due to a caller disconnecting or non-operational trunks becoming operational.

The ATB - Measure is the percentage of **callers** that receive a busy signal while trying to reach the call center because of an ATB situation, in relation to the total number of callers that attempted a call to the call center.

Any situation that disturbs the usual operation of the call center and results in extreme variances in the call center's performance level will be considered as an exceptional event and reviewed on a case-by-case basis.

Requirement

For all toll free lines, ATB is required to be reported. Currently this measure is for monitoring purposes. A future benchmark will be determined.

Calculation

$$\frac{\text{Period Attempts} - \text{Completed Calls}}{\text{Period Attempts}}$$

Data source

Interact

Data points

Number of Failed Attempts (Callers unable to access call center)

Number of Attempts (Total number of calls offered to call center)

Service Level Indicator – 60 Seconds

In most call centers, when a caller dials the call center number(s), they are first connected to the queuing system. The queuing system then performs one of the following operations:

If an IVR exists, the queue gives the caller the option of receiving automated information from the IVR or being placed directly into the queue to wait for a customer service representative (CSR). Those customers choosing the IVR option can still decide to exit from the IVR system and be returned to the queuing system to wait for a CSR.

If an IVR does not exist, the queuing system delivers them directly into a queue where they will wait for the next available CSR.

If a call center connects callers to an IVR, calls will be considered in queue only after they are delivered to the queuing system.

This service level indicator is the percentage of calls that are answered by a CSR within 60 seconds of their delivery to the queuing system. This measure does not include callers placed into the queue but abandoning their calls before 60 seconds.

Requirement

For callers choosing to talk with a CSR, no less than 85% of telephone calls should be answered within the first 60 seconds.

Calculation

$$\frac{\text{Answered <= 60 seconds}}{\text{(Calls in queuing system(s)) – (Abandoned <= 60 Seconds)}}$$

Data source

Call center's premise based equipment.

Data points

Answered <= 60 Seconds (Calls answered by CSRs within 60 seconds)

Calls in CSR Queue (Total Monthly calls delivered to CSR queue)

Abandoned <= 60 Seconds (Calls abandoned before or at 60 seconds in CSR queue)

Average Speed of Answer (ASA)

Average speed of answer (ASA) is the average time, in seconds, that all calls waited before being connected to a CSR. This includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately. In those call centers where the beneficiary and provider calls are delivered to the same queue and cannot be separated, report the combined ASA.

Requirement

Report monthly ASA in seconds. This measure is for service monitoring. A future benchmark may be established.

Data source

Call center's premise based equipment

Data points

ASA

Call Abandonment Rate (CAR) – For CSR Queue

The CAR is the percentage of callers abandoning prior to connecting with a CSR divided by the total number of calls delivered into the CSR queue. Abandoned calls will be tracked as two separate measures: calls abandoned up to and including 60 seconds and calls abandoned beyond 60 seconds.

Requirement

Report the number of abandoned calls from the CSR queue. This should be reported as two separate measures: 1) Calls abandoned up to 60 seconds, and 2) Calls abandoned after 60 seconds. These data elements are for monitoring and tracking purposes. A future benchmark may be established.

Calculation

Up to 60 seconds

$$\frac{\text{Calls Abandoned <= 60 seconds}}{\text{Calls in CSR Queue}}$$

Beyond 60 seconds

$$\frac{\text{Calls Abandoned > 60 seconds}}{\text{Calls in CSR queue}}$$

Data Source

Call center's premise based equipment

Data Points

Calls Abandoned <= 60 Seconds (Calls abandoned from CSR queue before or at 60 seconds)

Calls Abandoned > 60 Seconds (Calls abandoned from CSR queue after 60 seconds)

Calls in CSR queue (Total monthly calls delivered to CSR queue)

CSR Productivity

One of the goals of any call center is to effectively handle the greatest volume of calls with the most efficient use of dedicated resources. The CSR Productivity is a measure of the number of full-time equivalents (FTEs) required to provide the necessary service to the volume of callers who contact the call center. This does not include calls delivered to an IVR.

The FTE measure is based on 6.5 hours per day spent answering or ready to answer calls. The average number of FTEs is calculated by multiplying 390 minutes (6.5 hours) by the number of workdays in the month. Divide this number into the "Total Sign-In Time" for the month to arrive at the FTE measure. It does not include supervisors, support staff, etc., unless they periodically answer calls, at which point the amount of time they are logged into the system will be included in the total FTE amount.

Requirement

Track CSR call handling productivity. The CSR productivity is calculated by dividing the total CSR FTEs in the center into the total calls handled. For beneficiary call centers only, a minimum performance objective of 1100 calls per FTE per month for Non-Medicare Customer Service Center (MCSC) call centers and 1000 calls per FTE per month for MCSC call centers is required. A target has not been set for provider call centers.

Callback Completion

Calls not resolved by the CSR during the first call due to a need for further information, contact with another CSR, etc., may necessitate a callback to the caller from the CSR or someone else in the call center in order to resolve the inquiry. Callbacks in response to voicemail messages do not fall within this definition.

Callback completion measures the percentage of callbacks made within the required amount of time. This measure ensures that inquiries are resolved in an efficient and timely manner even when they cannot be resolved during their initial call.

Contact management systems should have the capability of tracking callbacks. After the initial call is received and a callback is deemed necessary, special conditions will be taken into consideration depending on the caller' request (i.e., a caller requests a callback "next week").

Requirement

Report the status of those calls not resolved at first contact. These data elements are for monitoring and tracking purposes. A future benchmark may be established. Those calls should be reported as follows:

Callbacks required (This is the number of callbacks required during the calendar month. The "cut-off" or the last day of the reporting period is the last workday of the month).

Callback closed within 5 workdays (This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month).

Calculation

$$\frac{\text{Number Callbacks in 5 workdays}}{\text{Number Callbacks Required}}$$

Data source

The call center's contact management system. Some call centers are performing this manually and is sufficient for reporting purposes.

Data points

Callbacks required
Callbacks closed within 5 workdays

Average Talk Time (ATT)

The ATT is a measure of the average length of each call once a caller reaches a CSR. Included in talk time would be any time that the caller was placed on hold during the call.

The length of time necessary to address a question or issue can provide insight into the complexity of questions being asked, the level of training of the CSR, and the resources available to the CSR to effectively address issues.

Requirement

Report monthly ATT, targeting call duration between 3 and 7 minutes (180-420 seconds). This is for measurement purposes only.

Calculation

$$\frac{\text{Talk Time}}{\text{Calls Answered by CSRs}}$$

Data source

Call center's premise based equipment

Data points

Talk time (total seconds CSRs are connected to callers per month)
Calls answered by CSRs

After Call Work Time (ACW)

The ACW measures the average time it takes CSRs to perform the necessary actions and documentation after a call is completed. These actions include mailing a form, contacting another CSR or supervisor with specific expertise, and documenting the reason for the call and its resolution.

The ACW is a good indicator of the level of efficiency of the call center's processes and information management. For example, a high average ACW may indicate that CSRs are spending their time doing tasks that could be centralized, such as form mailing. It may also indicate that the interface through which they document information is too slow or complicated, or that information is not readily available.

Requirement

Report monthly ACW time. This is for measurement purposes only.

Calculation

$$\frac{\text{After Call Work Time}}{\text{Calls Answered by CSRs}}$$

Data source

Call center's premise based equipment

Data points

ACW (total seconds spent by CSRs performing ACW)
Calls answered by CSRs

Occupancy Rate

Occupancy is the percent of time CSRs were plugged-in, logged-in, handling calls, making outgoing calls, or in the after call work state.

Occupancy is a good indicator of the extent to which call handling resources are utilized to handle beneficiary telephone inquiries. When CSRs are engaged in non-telephone work, the occupancy rate declines.

Requirement

Report the monthly Occupancy rate.

Calculation
Active Call Handle Time

$$\text{Total Sign In Time}$$

To determine the Active Call Handle Time:

Total Sign In Time – CSR Available Time = Active Call Handle Time

Data source

Call center's premise based equipment

Data points

Occupancy rate (the percent of time CSRs were plugged-in, logged-in, handling calls, making outgoing calls, or in the after call work state).

IVR Handle Rate

Callers can be delivered to the IVR either through direct connection at the beginning of a call or through the caller's selection of the IVR option.

The IVR handle rate is the percentage of calls handled in the IVR divided by the total monthly calls offered to the IVR. For measurement purposes, calls handled in the IVR is defined as any call delivered to the IVR where the caller (1) selected and played at least one informational message; and (2) did not subsequently transfer to a CSR.

Requirement

This measure is for monitoring and tracking purposes. A future benchmark may be established.

Calculation

$$\frac{\text{Number of Calls Handled by IVR}}{\text{Number of Calls Offered the IVR}}$$

Data source

Call center's premise based equipment and IVR reports

Data points

Number of calls offered the IVR

Number of calls handled by IVR (total monthly calls delivered to the IVR where the caller (1) selected and played at least one informational message and (2) did not subsequently transfer to a CSR.